Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935
1400 E. Washington Avenue
Madison, WI 53703
FAX #: (608) 266-2264
Phone #: **(608) 266-7482**
E-Mail: web@drl.state.wi.us
Website: http://drl.wi.gov

DIVISION OF ENFORCEMENT

AUTHORIZATION FOR RELEASE OF INFORMATION

COMPLETION OF THIS FORM IS VOLUNTARY

Patient's Name: _____ Patient's Date of Birth: _____

I, hereby authorize _____

and all staff or employees of that facility or office to provide the Wisconsin Department of Regulation and Licensing (Department) and its attached Boards, or any attorney, investigator, employee, or agent thereof, with copies of all health care records relating to the above named patient in your possession or under your control, regardless of origin, including, but not limited to, the following: admission records, physical examinations and histories, nurses' notes, progress notes, diagnostic test records, physician notes and orders, medication orders and records, operative reports, laboratory work, prescription and dispensing records, x-ray films, radiology reports, anesthesia records, physical therapy records, occupational therapy records, respiratory therapy records, consultation reports, pathology reports, emergency room records, discharge summaries, drug and alcohol treatment records, and mental health/psychiatric treatment records. This is to include records relating to HIV treatment, if such treatment has been given. I further authorize you to allow these persons to examine and copy any records or information relating to the above named patient. A reproduced copy of this Authorization Form shall be as valid as the original.

This disclosure is being made for the purposes of a legal inquiry and any subsequent proceedings by the Department and its attached Boards. Unless revoked earlier, this consent regarding records is effective until two (2) years from the date of signature. I understand that: (a) I may revoke this authorization regarding records at any time by sending a written notice of revocation to the Department at the above address; (b) information obtained as a result of this consent may be used after the above expiration date or revocation; (c) the information that the Department receives under this request will not be re-disclosed except in the case of a Department or board proceeding, or a valid open records request and then only under the circumstances permitted by law; and (d) the completion or non-completion of this consent in no way effects any treatment, payment, enrollment or eligibility for benefits by any health care provider.

I have been informed, pursuant to Wis. Adm. Code § HSS 92.03(3)(d), that I have the right to inspect and receive a copy of any mental health treatment record materials which are disclosed as a result of this authorization, as required under Wis. Adm. Code sections HSS 92.05 and 92.06.

I further authorize you to discuss with these persons, any matters relating to the treatment of the above named patient.

_____ _____

Date Signature (First, Middle, Last)

_____

Authority for Signing (i.e., Parent of Minor; Guardian of Ward or Incompetent; Personal Representative or Spouse of Deceased)

[PLEASE BE SURE TO READ THE INSTRUCTIONS FOR COMPLETION OF THIS FORM]

#2004 (Rev. 5/05)
Sec. 440.03, Stats.
Sec. 146.82, Stats.

-OVER-

Wisconsin Department of Regulation & Licensing

INFORMATION ABOUT AUTHORIZATION FORMS

COMPLETE AND RETURN AUTHORIZATION FORMS ONLY IF YOUR COMPLAINT INVOLVES A HEALTH CARE PROFESSIONAL.

Authorization Forms give your permission for our agency to obtain copies of treatment records, discuss that treatment with the persons who provided the treatment, and use the records as part of our inquiry and/or investigation of the complaint and, if necessary, during any hearing that might follow.

You will find an Authorization Form attached to this sheet. You may make additional copies of this blank form to cover additional facilities and/or offices where treatment was provided.

INSTRUCTIONS:

The patient, or other person, if this is legally allowed, will need to fill in the blanks on the form before signing the form and returning it to us.

- **Patient's Name:** Insert the name of the patient whose records we will be requesting.
- **Patient's Date of Birth:** This will be necessary to identify the patient.
- **I, hereby authorize** _____

  Insert the name of the individual or facility which treated the patient:

  Examples: " Metropolitan Hospital "
  " Dr. Jane Doe "
  " Southside Dental Clinic "

- **Date:** Put the date the form is signed
- **Signature:** Sign the form legibly.
- **Authority for signing:** If the patient is a minor, is deceased, or is not competent to sign, the parent, legal guardian, next of kin, or estate representative should sign:

  Examples: " James Smith, parent of Michael Smith, a minor child "
  " Mary Jones, surviving wife of Henry Jones, deceased "
  " Steve Green, personal representative for Sandy Blue "

MAIL TO:

Department of Regulation and Licensing
Division of Enforcement
P.O. Box 8935
Madison, WI 53708-8935

If you do not include the completed Authorization Form(s), we may not be able to investigate your complaint.

If you have any questions about completing the Authorization Form, please contact the department staff at (608) 266-7482.

Thank you for taking the time to complete this document.